Medical History Form Today's date: ____________________________

Greater Washington Maternal Fetal Medicine & Genetics

Name: ____ Date of birth: __________ Age: ______

Baby's father's name: __________________________________ Date of birth: __________ Age: ______

Referring physician: __________________________________ OB office location (city): ______________________________

Preferred pharmacy: ____

Why have you been referred to us?: ____

Have you been seen at our office previously?: ☐ Yes ☐ No *If yes,* when?: _______________

Your height: __________ Your weight **before** pregnancy: __________ Your **current** weight: __________

What is your blood type? _________________

Are you allergic to any medications? ☐ Yes ☐ No *If yes,* please list:

Are you allergic to latex? ☐ Yes ☐ No ____

Current Pregnancy:

When was the first day of your last menstrual period?: ________________________

When is your due date?: ________________________ This is based on: ☐ last period ☐ early ultrasound ☐ fertility treatment

Is this a twin/triplet pregnancy?: ☐ Singleton ☐ Twins ☐ Triplets ☐ Other: __________________

Was this current pregnancy achieved by fertility treatment?: ☐ Yes ☐ No

Which method was used?: ☐ IUI ☐ IVF ☐ Other: __________________________

If IVF, what type of cycle was it?: ☐ Fresh ☐ Frozen

If frozen cycle, how old were you when you did your egg retrieval?: _____ years old

Was this pregnancy achieved by donor egg?: ☐ Yes ☐ No

If yes, how old was the donor?: _____ years old

Was this pregnancy achieved by donor sperm?: ☐ Yes ☐ No

Was the embryo tested for chromosome disorders?: ☐ Yes ☐ No

Was the embryo tested for any other genetic disorder?: ☐ Yes ☐ No *If yes,* what disorder?: ____________________

Genetic Testing:

Have you had genetic screening or carrier screening done during or prior to this pregnancy?: ☐ Yes ☐ No

Examples include screening for sickle cell disease, cystic fibrosis, fragile X or SMA or pregnancy screening such as first trimester screening, quad screen, non-invasive prenatal testing (NIPT)

If yes, what were the results?

____

____

Have either you or the baby's father ever had a chromosome study?: ☐ Yes ☐ No

If yes, what were the results? ____

Gynecologic history: Have you had any of the following? If yes, provide date and additional information.

☐ Yes ☐ No	Laser, cryotherapy of the cervix		
☐ Yes ☐ No	Sexually transmitted infection		
☐ Yes ☐ No	Abnormal Pap smear		
☐ Yes ☐ No	LEEP		
☐ Yes ☐ No	Cold knife conization of the cervix		
☐ Yes ☐ No	Myomectomy		
Other gynecological surgery:			

Name: ________________________________ **Date of Birth:** ______________________________

Pregnancy history: Please list all pregnancies from first to last (not including your current pregnancy).

Year	*Choose one:* - Live Birth - Fetal loss after 20 weeks - Miscarriage before 20 weeks - Termination	*Choose type of delivery:* - Vaginal - Cesarean - Forceps/Vacuum	Weeks of gestation at delivery	Infant's birth weight	Gender	Pregnancy complications?	Newborn complications?

Have you experienced any of the following in a previous or current pregnancy?

Pre-term labor: ☐ previous pregnancy ☐ current pregnancy
High blood pressure/preeclampsia: ☐ previous pregnancy ☐ current pregnancy
Diabetes or gestational diabetes: ☐ previous pregnancy ☐ current pregnancy
Blood or clotting disorders: ☐ previous pregnancy ☐ current pregnancy
Incompetent cervix/cerclage: ☐ previous pregnancy ☐ current pregnancy

Medications: Please list your current medications (prescription, over-the-counter, supplements, inhalers).

Medication	Dose	How often taken	Reason

Are you taking blood thinners?: ☐ Yes ☐ No

Medical History: Have you had any of the following conditions? If so, include the date of onset.

☐ Diabetes	☐ Respiratory disease
☐ Thyroid disorder	☐ Blood clots/clotting disorder
☐ Polycystic ovarian syndrome (PCOS)	☐ Seizure disorder
☐ High blood pressure	☐ Migraine headaches
☐ Heart disease/defect	☐ Mental health problems
☐ Kidney disease/recurrent urinary/kidney infections	☐ Lupus, or other auto-immune disorders
☐ Hepatitis	☐ Cancer
☐ HIV	☐ Other:

Have either you or the baby's father ever had a bone marrow or stem cell transplant?: ☐ Yes ☐ No

Surgical History: Have you had any of the following procedures? If so, please include dates.

☐ Yes ☐ No	Tonsils removed	☐ Yes ☐ No	Cesarean delivery
☐ Yes ☐ No	Gall bladder removed	☐ Yes ☐ No	D&C
☐ Yes ☐ No	Appendix removed	Other:	

Have you had a prior hospitalization (not including childbirth)?: ☐ Yes ☐ No *If so,* list dates and reason.

Are there any other issues regarding your obstetrical, medical, or family history that we should be aware of?

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Patient's signature: ____ Date: ____________